Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF PRIMARY HYDATID OF BONE.

BY C. E. RUSSEL RENDLE, F.R.C.S. EDIN.,
LATE ASSISTANT SURGEON, SOUTH DEVON AND EAST CORNWALL HOSPITAL.

THE patient, a woman aged 67 years, came as an out-patient to the South Devon and East Cornwall Hospital complaining of the inconvenience caused by a large tumour over the sacral region, which prevented her sitting or lying back with any comfort. She had a small lipoma in the right hypochondrium which had been there for over thirty years, and stated that the lump behind had been gradually enlarging for nearly four years. It measured about 10 in. by 6 in., was situated over the right sacrum and sacro-iliac joint, extending a little beyond the middle line; it was dull to percussion, of doughy consistency, no thrill, no definite fluctuation. I admitted her with a view of removing the tumour, which I took to be a lipoma or thyroid dermoid.

The tumour was more or less definitely encapsuled, but while freeing the base, which was firmly attached over the end of the ilium, I cut across a tube with a glistening membrane which turned out to be the lining of a hydatid cyst. A probe passed some 4 or 5 inches through a very small opening into apparently a bony cavity. I enlarged the opening and scraped out a considerable quantity of membrane and daughter cysts and drained the cavity. There seemed no connexion with the abdomen. The patient went on very well for some time, the wound gradually closing up, but she was the subject of chronic bronchitis, which troubled her a good deal, and suddenly her heart began to fail, and she died in two days.

At the post-mortem examination no hydatid could be found in any other organ of the body; the brain was not examined, but there was no reason to suspect anything wrong there. The ilium was found to be hollowed out into a large irregular cavity, with the remains of some membrane, and I can only conclude that it was the situation of the primary cyst, which had expanded and thinned the posterior margin, and finally burst through and overflowed into the subcutaneous tissues of the back. The patient had never been abroad, but had lived all her life in the neighbourhood.

NOTE ON THREE CASES OF SPLENIC ABSCESS OCCURRING IN SO-CALLED "MALARIAL CACHEXIA."

BY F. E. WILSON, M.B., CH.B. EDIN.,
CAPTAIN, I.M.S., AGENCY SURGEON, MESHED, PERSIA.

DURING the past few years I have been struck with the frequency of splenic abscess occurring in cases of so-called "malarial cachexia," and by the disappearance of the "cachexia" on treatment directed against the local condition. So common is it in my experience that I now make it a practice to look carefully for evidences of splenic suppuration in all cases of malaria with splenic enlargement which are resistant to ordinary treatment.

The points on which I rely in making a diagnosis in such cases are: (1) Continuance of fever under thorough quinine treatment and after the disappearance of all forms of the parasite from the peripheral blood; (2) local evidences of softening, pain, or adherence to the abdominal parietes; and (3) leucocytosis. What probably occurs in the spleen is the necrosis of areas of hypertrophied splenic tissue, this being followed by infection from the blood stream. Unfortunately I have not had the laboratory facilities at my disposal to determine the infecting organism in each instance. Below I append short notes of three cases.

CASE 1.—Male, aged 45, Tochi Valley; a small poorly developed man in advanced cachexia. The spleen was adherent to the abdominal wall, which was ideally thin for palpation. About 1½ pints of viscid, yellow pus were removed, and a soft drain was left in the wound. The man went out very much improved.

CASE 2.—Male, aged 35, Peshawar; in advanced cachexia. The adhesions were less firm in this case, and the surface of the spleen was first stitched to the abdominal wall before opening the abscess. About a quart of pus escaped, followed by a sharp hæmorrhage, but this was controlled by hot saline adrenalin solution. In spite of careful nursing the patient died from exhaustion three weeks later.

CASE 3.—Male, aged 30, Meshed; cachexia not marked. Recent scars from some native actual cautery over the splenic area. A pointing abscess in the abdominal wall leading into the large adherent spleen was opened, the lower margin of the spleen being very hard. About 1¼ pints of thick pus escaped, being followed by slight hæmorrhage. Microscopically this pus contained leucocytes, myelocytes, a variety of organisms, but no malarial parasites. The patient went out greatly improved.

I have ventured to record these cases in the hope that the short notes may be of use to those who are working in tropical or subtropical climates, by directing attention to a common but little described cause of the persistence of apparent malarial cachexia.

NOTE ON A CASE OF ACUTE PULMONARY ŒDEMA IN AN INSANE PATIENT.

BY J. F. CORSON, M.D. VICT., D.P.H. CAMB.,
LATE ASSISTANT MEDICAL OFFICER TO THE BUCKS COUNTY ASYLUM.

THE following case of death from acute pulmonary œdema is of some interest on account of the existence of a peculiar delusion of persecution which may have been associated with a previous pulmonary attack. My acknowledgments are due to Dr. H. Kerr, the medical superintendent of the Bucks County Asylum, for permission to publish the case.

The patient, a female, 30 years of age on admission, was admitted to the Bucks County Asylum on July 16th, 1895. She was pregnant and gave birth to a child four days after admission. Her mental state at that time was one of depression, with anxiety and fears of persons entering her room. She was thin and rather anæmic, and her heart sounds were described as weak and muffled, but it is stated that there was no cardiac murmur. Her health improved and she became fat, and except for some slight degree of anæmia appears to have shown no symptoms of physical disease until her death. Her mind did not recover, and she became chronically maniacal, with frequently recurring exacerbations and remissions. About six months before her death she complained that another patient had put soap into her mouth whilst she was asleep in bed, and that it had nearly choked her. This was not regarded at the time as having any special significance. Her general health continued good, and she worked steadily at the ordinary housework of an asylum ward.

On April 1st, 1911, the patient was found dead in bed at 10.15 P.M. by the night nurse. When I saw her she was lying on her back, her nose and lips were covered with white froth, and her lips were livid. According to the accounts of fairly reliable patients in the same dormitory, she got out of bed shortly before 10 o'clock, and was seized with a severe attack of coughing. She returned to bed and the coughing continued for some minutes, and she complained of pain in the chest. She was quiet afterwards, and was thought to be better again.

At the post-mortem examination the heart was found to be hypertrophied, and weighed 12 oz. There was marked stenosis of the mitral orifice; the mitral valve was thickened and there were small vegetations on the cusps. The aortic valve cusps also showed small vegetations. Both lungs were distended and filled with frothy exudation.

The case appears to have been one of acute pulmonary œdema, and the delusion that soap had on one occasion been put into her mouth during sleep may have arisen from a previous attack.